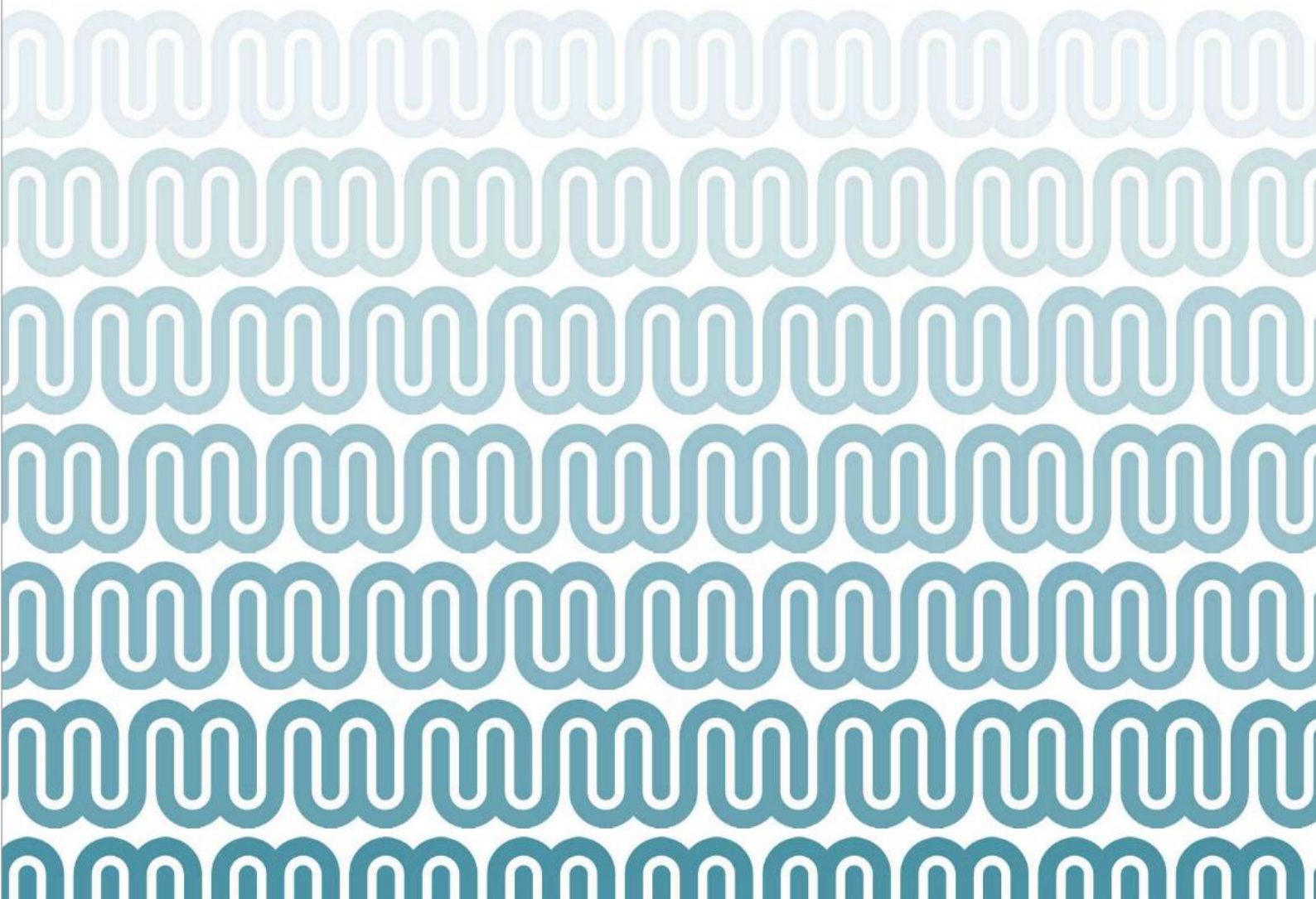




mental welfare
commission for scotland

Authority to discharge: Report into decision making for people in hospital who lack capacity

May 2021



Our mission and purpose

Our Mission

To be a leading and independent voice in promoting a society where people with mental illness, learning disabilities, dementia and related conditions are treated fairly, have their rights respected, and have appropriate support to live the life of their choice.

Our Purpose

We protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

Our Priorities

To achieve our mission and purpose over the next three years we have identified four strategic priorities.

- To challenge and to promote change
- Focus on the most vulnerable
- Increase our impact (in the work that we do)
- Improve our efficiency and effectiveness

Our Activity

- Influencing and empowering
- Visiting individuals
- Monitoring the law
- Investigations and casework
- Information and advice

Foreword – Julie Paterson, chief executive



'People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society'

People are admitted to hospital for specialist care and treatment based on their health needs. When people are clinically well enough to then leave hospital, they should receive all necessary information and support to return to their home, whether that is their own house or an alternative community setting which is their home. It is not in anyone's interests to stay in hospital when there is no clinical reason to do so. Planning discharge from hospital is therefore critical to ensuring that people leave hospital fully included in decision making, fully informed and with appropriate support. For those people who do not have the capacity to fully participate in discharge planning processes, legal frameworks must be considered to ensure appropriate lawful authority and respect for the person's rights. All adults have the right to receive the right support at the right time in the right setting for them.

In this report we decided to combine concerns about moves from hospitals to care homes during the early months of pandemic restrictions with a recent judicial review case we were involved in to find out more about the legality of hospital to care home moves.

This report is based on information submitted to us by Health and Social Care Partnerships (HSCPs).

It finds cases of reported unlawful moves.

Some of the practice concerns relate specifically to the pandemic. But, worryingly, the report also finds more endemic examples of poor practice, not specifically pandemic related. Lack of understanding of the law, lack of understanding of good practice, confusion over the nature of placements, misunderstanding over power of attorney. These findings are disappointing and may mean that many more moves were made without valid legal authority.

This report also finds a lack of uniformity from one HSCP to another, with different approaches to national legislation and guidance adopted in different areas.

Our report raises significant questions of training and approach in Health and Social Care Partnerships - issues that are dealt with in our recommendations.

Chief Officers of Health and Social Care Partnerships provided information as requested and, from the outset, shared the Mental Welfare Commission's commitment to identifying any learning and/or recommendations for improvements in practice. We hope that leaders of HSCPs and the Care Inspectorate, as regulatory body, now take recommended action to improve practice and outcomes for the most vulnerable adults in our society.

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Executive Summary

The Adults with Incapacity (Scotland) Act 2000 introduced a system for safeguarding the welfare and managing the finances and property of adults who lack capacity to make some or all decisions for themselves. This legislation is underpinned by principles of benefit to the adult, taking account of the person's wishes and the views of relevant others. Any action must be the least restrictive option necessary to achieve the benefit and importantly to encourage the adult to exercise whatever skills he or she has in relation to their welfare, property or financial affairs and develop new skills where possible recognising issues of capacity are not 'all or nothing', they are decision specific.

The Mental Welfare Commission has a statutory safeguarding role in respect of adults whose capacity to make decisions or to take actions to promote or safeguard their welfare is impaired due to a mental disorder. During the Coronavirus pandemic, a number of stakeholders raised concerns with the Commission regarding whether the appropriate legal authority was used to safeguard people being discharged from hospital to care homes who did not have the capacity to make an informed decision to agree to the move.

People who lack mental capacity and who are being cared for and treated in care homes and hospitals are among the most vulnerable in our society. The focus of this report was to examine the detail of a sample number of hospital to care home moves of people from across Scotland, to check that those moves were done in accordance with the law during the early stages of the pandemic.

The Commission therefore undertook to make further inquiries and sought information from Health and Social Care Partnerships (HSCPs) across Scotland in relation to people who had moved from hospital to registered care home settings during the period 1 March 2020 – 31 May 2020 (our sample period). HSCPs were very responsive to our request. Only Highland did not provide information within the timescale requested.

From those returns, we asked for information about 731 people from across Scotland, 465 of whom were reported by HSCPs to have lacked capacity to agree to a move from hospital to a care home (8 of whom in turn did not fulfil the inclusion criteria for this inquiry). Whilst all individuals should receive full information as to their rights in relation to discharge from hospital and outcomes to be achieved to allow them to exercise those rights, our work focussed on those (457) people reported as lacking capacity to do so (our sample size corresponded to approximately 10% of all discharges from hospitals to care homes reported by Public Health Scotland).

It was reported to us that people had been moved during the sample period without the protection of legal authority. These unlawful moves (involving 20 people) took place across 11 Health and Social Care Partnership areas. We learned that, for some of these moves, there had been specific pandemic related reasons for this. For example, a misinterpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and was removed in September 2020. We also found that one HSCP introduced an alternative to applications for guardianship orders, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020. The Commission does not provide legal advice so we asked whether legal advice had been sought in relation to both these practices; confirmation was given that legal advice had been sought and given

The Commission's significant concern is that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of European Convention on Human Rights (ECHR).

Section 13ZA of the Social Work (Scotland) Act 1968 was reportedly used to authorise moves in 23 Health and Social Care Partnerships and either Welfare Power of Attorney or guardianship orders were used to authorise moves across 30 of the 31 Health and Social Care Partnerships.

We took further steps to analyse to assure legal rights were respected and protected beyond the 20 unlawful moves. For example, we asked questions about the 338 moves said to have been authorised using a Welfare Power of Attorney or Adults with Incapacity legislation. We found that those working in the field of hospital discharge were not always fully sighted on the powers held by attorneys or guardians (this was the case in 78 out of 267 cases of power of attorney related moves) or indeed whether the attorney's powers had been activated or guardianship orders granted. Whilst it is difficult to quantify the impact, our view is that such assumptions, rather than evidence based decision making, had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR.

We also found confusion in relation to the reported nature of the care home placement with potential impact on rights to protection of property where the person was admitted to a care home but remained liable for their property.

We established that practice was not consistent either within some HSCPs or across HSCPs. Indeed some HSCP staff had experience of working across HSCPs and reported that moving from one HSCP to another brought differences in practice into sharp focus. This is despite a range of existing guidance, policy and local arrangements to support implementation.

In summary, we found that whilst the pandemic brought significant pressures, the identified areas for improvement arising from our examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. Our findings indicate longer standing systemic issues within HSCPS which require urgent action to address in order to safeguard and uphold the rights of the most vulnerable adults in our society. To this end, we have made eleven recommendations that we hope will assist HSCPs.

Recommendations

Based on our findings we recommend the following areas for improvement:

Recommendation 1: HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in this report) to inform delivery of training programmes to ensure a confident, competent multidisciplinary workforce supporting safe and lawful hospital discharge planning.

Recommendation 2: HSCPs should establish a consistent system for recording when an assessment of incapacity has been conducted, by whom and in relation to which areas of decision making.

Recommendation 3: HSCPs should ensure that staff facilitating hospital discharges are clear about the status of registered care home placements, in terms of law (see EHRC vs GGC)¹ and with regards the financial and welfare implications of different types of placements for the individual.

Recommendation 4: HSCPs should ensure that practitioners facilitating hospital discharges have copies of relevant documents on file detailing the powers as evidence for taking action on behalf of the individual who is assessed as lacking capacity.

Recommendation 5: HSCPs should ensure that assessments reflect the person as a unique individual with focus on outcomes important to that individual and not external drivers that have the potential to compromise human rights and/or legality of moves.

Recommendation 6: HSCPs should ensure that processes are in place to audit recording of decisions and the legality of hospital discharges for adults who lack capacity in line with existing guidance and the principles of incapacity legislation.

Recommendation 7: HSCPs' audit processes should extend to ensuring evidence of practice that is inclusive, maximising contribution by the individual and their relevant others, specifically carers as per section 28 Carers (Scotland) Act 2016.

Recommendation 8: HSCPs should ensure strong leadership and expertise to support operational discharge teams.

Recommendation 9: The Care Inspectorate should take account of the findings of this report regarding the use of s.13ZA of the Social Work (Scotland) Act 1968 and consider the scrutiny, assurance or improvement activity to take in relation to this.

Recommendation 10: The Care Inspectorate should take account of the broader findings of this report beyond use of s.13ZA and consider how this might inform future scrutiny, assurance and improvement activity in services for adults.

Recommendation 11: The Scottish Government should monitor the delivery of the above recommendations and work with Health and Social Care Partnerships and the Care Inspectorate to support consistency and address any barriers to delivery over the next two years.

¹ Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Greater Glasgow and Clyde* [online] Available at: <https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention> (Accessed 19 April 2021).

Introduction

The Mental Welfare Commission has specific legal duties in relation to safeguarding the rights of people who are subject to the welfare provisions of the Adults with Incapacity (Scotland) Act 2000 ('the AWI Act').

Section 9 of the AWI Act details the Commission's safeguarding role in respect of adults whose capacity to make decisions or to take actions to promote or safeguard their welfare is impaired due to a mental disorder.

Local intelligence gathering and calls to the Commission's advice line in the early stages of the Covid-19 pandemic suggested that people who were in hospital and lacked capacity may have been moved from hospital to care homes without full understanding of the legal requirements to ensure rights are upheld and the move to care was lawful. Specific concerns related to the use or otherwise of Section 13ZA of the Social Work (Scotland) Act 1968 particularly in the context of the Coronavirus (Scotland) Act 2020 ('the Coronavirus Act').

In addition, the Mental Welfare Commission were party to a Judicial Review led by the Equality and Human Rights Commission (EHRC) during this period. This Judicial Review concluded in December 2020 when NHS Greater Glasgow and Clyde (NHSGGC) and the owner of a chain of care homes, agreed to end the practice of placing patients in care homes without legal authority.² As a result of this agreement and commitment by NHSGGC to work with its partner local authorities to make sure that all patients and their families know what is happening and what their rights are in relation to discharge from hospital, EHRC stopped legal proceedings.

Given the concerns raised directly with us and the context of the Judicial Review involving NHSGGC, we wrote to Chief Officers of Health and Social Care Partnerships across Scotland in October 2020 seeking information in relation to people discharged from hospital to care homes. The intention was to identify whether or not there was evidence of unlawful moves from hospitals to care homes beyond that already confirmed in NHSGGC.

The focus of our work was therefore on people who were assessed as lacking capacity, the legal authority used to facilitate their moves from hospital to care homes and the evidence which confirmed that good practice (well documented in existing policy and guidance) had continued to be followed in the context of the significant challenges faced in the first three months of the Coronavirus pandemic.

Chief Officers of Health and Social Care Partnerships provided us with all information requested and shared the Mental Welfare Commission's commitment to identifying any learning and/or recommendations for improvements in practice. The only Health and Social Care Partnership which did not provide us with information, as requested, within timescale, was Highland. Highland's information is therefore not included as part of this piece of work.

² Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement*

What we did

The current project aimed to explore, within a sample of all moves reported, whether there were any unlawful moves of individuals, who were assessed as lacking capacity, from hospital into care homes.

We requested information from all 31 Health and Social Care Partnerships (HSCPs) in Scotland relating to all moves from hospitals to registered care homes that took place between 1 March 2020 and 31 May 2020. The information included i) name of the individual, ii) date of birth, iii) name of the care home the individual was moved to, and iv) contact details for the key contact person or team from the HSCP.

Highland did not provide information, as requested, within the timeline required. From the submitted information from all other HSCPs, we aimed to undertake further review of 500 cases of individuals who moved during this time period and who were assessed as lacking capacity to consent to the move. This corresponded to approximately 10% of all discharges from hospitals to care homes reported by Public Health Scotland (PHS).³

We randomly selected cases based on geographical location and age and reviewed a total of 731 cases for inclusion (see more detailed methodology in Appendix A). Of these, it was reported to us that 465 (64%) people were assessed as lacking capacity to make an informed decision in relation to a move to a care home and 266 (36%) people reportedly had capacity to consent to the move. After excluding eight cases that ended up not fulfilling our inclusion criteria, the sample on which this report is based is 457 cases (93% of our target sample).

³ Public Health Scotland. (2020). *Discharges from NHS Scotland hospitals to care homes*. Available at: <https://beta.isdscotland.org/find-publications-and-data/population-health/covid-19/discharges-from-nhsscotland-hospitals-to-care-homes/> (Accessed 5 May 2021).

Nature of Placement

What we expected to find

We wanted to know about the individual's move from hospital to the care home placement and asked each HSCP to tell us whether the move was permanent, temporary or on a respite basis. We would not routinely expect placements from hospital to a care home to be on a respite basis.

Where an individual is ready for discharge, we would expect decisions about ongoing care and support to focus on the needs of the individual and on achieving the best possible outcome for that individual. The decisions should be made through a multi-disciplinary process in consultation with the individual, family/carer and all agencies involved in planning the discharge. The individual should receive all relevant support and information to make an informed decision about future care options, including their right to appeal discharge from hospital should they disagree with the clinical assessment.⁴

The assessment that is undertaken at this stage is a significant part of the discharge planning process that determines the level of support, care and treatment that the person will need in order to lead a fulfilling life on discharge. It is important that this discharge planning starts as early as possible during an individual's admission to hospital, maximising their participation, maximising inclusion of any family/carers (section 28 Carers (Scotland) Act 2016) and maximising the involvement of key agencies such as social work, housing and community support.

The role of social work is critical in facilitating and coordinating discharges from hospital. Social work practice is underpinned by principles of social justice, human rights and anti-discriminatory practice. It necessitates a multi-disciplinary knowledge base and skill set along with a non-judgmental and compassionate value base. Local authorities have a duty under the Social Work (Scotland) Act 1968 (Choice of Accommodation) Directions 1993 to arrange places for individuals in a care home of their choice provided that the accommodation is suitable in relation to the person's assessed needs and whether they require ongoing long term care.⁵

Where an assessment recommends that an individual requires long term care in a care home then the person must be involved in the process of choosing that care home. This would be known as a permanent move. *Choosing a Care Home* was produced in 2013 by the Scottish Government and specifically outlines guidance for staff on discharge planning and supporting people through the process.⁶

The guidance suggests that, wherever possible, decisions about long term care should not be made in an acute hospital setting. Ideally, the person should be discharged to a more appropriate non-acute setting such as a community hospital or intermediate care facility for further rehabilitation and assessment.⁷

⁴ Scottish Government. (2015). *Hospital Based Complex Clinical Care*. Available at: [https://www.sehd.scot.nhs.uk/dl/DL\(2015\)11.pdf](https://www.sehd.scot.nhs.uk/dl/DL(2015)11.pdf) (Accessed 5 May 2021).

⁵ Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).

⁶ Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).

⁷ Scottish Government. (2013). *Guidance on Choosing a Care Home on Discharge from Hospital*. Available at: http://www.sehd.scot.nhs.uk/mels/CEL2013_32.pdf (Accessed 5 May 2021).

The assessments referred to above must ensure the provision of access to appropriate support so that the person's rights, will and preferences are genuinely reflected in decisions made that concern them. This should extend to those people who are assessed as lacking capacity to fully participate in the decision making about their future long term care needs and who are moving to a care home or other registered setting. This reflects the requirements of the UN Convention on the Rights of Persons with Disabilities which the Scottish Government is committed to upholding.

Whilst the circumstances during the period for which we collected data were unprecedented as a result of the pandemic, the legislative framework protecting those assessed as lacking capacity remained intact as a critical safeguard.

What we found

We found that 253 of the individuals in our sample (44%) were still in the care home they were admitted to following discharge from hospital when we made contact.

Out of our sample of 457, 337 (74%) had moved on a permanent basis, 113 (25%) had moved on a temporary basis and seven (1%) had moved on a respite basis.

Permanent placements

Of the individuals who moved to a care home on a permanent basis, 131 (39%) were no longer in the care home due to a range of the following reasons:

- re-admitted to hospital
- first choice of home became available
- placement at the care home had broken down
- the care home had closed
- the person had died.

Temporary placements

We wanted to know about moves that were identified as being temporary; 113 people moved on a temporary basis. Where a preferred choice of care home is not immediately available an individual may require to make a temporary (interim) move to another home with a suitable vacancy to wait on the care home of their choice.

Although this was the case for some of the individuals in our sample, we found that there were further reasons why the moves were classed as temporary.

HSCPs told us that there was pressure on wards to clear beds due to the pandemic and that resources had been developed in the community to support this.

We found that HSCPs were often not clear about the nature of placement as there were examples where we were told that it was a temporary placement because the person had moved to an NHS bed within a care home:

"A placement being referred to as a hospital placement but was actually a residential care home registered with the Care Inspectorate. It was referred to as an NHS to NHS transfer and social work services were not involved in the move until the person was required to be moved to a long-term placement. As a result this meant the person was moved from an acute hospital to an interim care home bed and then to a long-term care placement".

We were told about other individuals who moved without the agreement of social work and social workers were advised after the event with the explanation that:

"These moves had been organised by health, often because wards were being cleared for Covid patients."

We found that 43 (38%) of the 113 people who had been moved to a care home on a temporary basis were still in the same care home that they were initially moved to. Some of the reasons we were told why the move was a temporary placement are found below:

- First choice of home wasn't available
- In order for a full social work assessment to be undertaken
- Needed an interim move
- Had to move due to COVID
- Intermediate care facility to undertake assessment
- Needing rehabilitation.

Of the 43 temporary moves, we were told that 20 placements (47%) had been made permanent between the time of the move and our review. Examples of these cases were:

- Moved on a temporary four week placement to enable a full social work assessment of need. The placement was subsequently made a permanent placement.
- Moved initially as a temporary arrangement however was settled so remained there on a permanent basis.

We were told that some individual moves were temporary as the person required intermediate care. Intermediate care is a multidisciplinary service that can support people to be as independent as possible by providing support and reablement to individuals at risk of hospital admission or who have been in hospital.⁸ For a care home to offer intermediate care facilities, the care home requires to register this facility/service with the Care Inspectorate. It was not always clear from HSCPs that the care home setting was registered for this specialist service, however we heard of people returning back home to live, so the outcomes were positive.

Respite placements

We were told that the nature of the placement for some individuals was identified as respite. Respite care means that the usual family/carer gets a break from their caring responsibilities, while the person cared for is looked after by someone else. However, we found that some of these individuals continued to remain at the care home and there appeared to be a lack of clarity about the nature and purpose of respite care in these instances.

Equally this too could have significant implications for a person's housing and financial affairs as they meet the costs of prolonged respite care whilst maintaining the funding for their accommodation in the community.

Identifying the nature of the placement (temporary, permanent, respite) for a person being discharged from hospital is not merely an administrative requirement - it can have significant impact on the person's welfare, property and finances. Confusion over whether placements are NHS or registered with the Care Inspectorate also has significant implications related to legal authority for moves and the human rights of the individual.

Professional holistic social work assessments are undertaken to ensure that all community care options are considered based on the unique individual needs of the person. We received feedback from HSCPs that suggested a focus on beds rather than people. This raises significant concerns in relation to the rights, will and preferences of the most vulnerable adults who lack capacity.

⁸ Scottish Government. (2012). *Maximising Recovery, Promoting Independence: An Intermediate Care Framework for Scotland*. Available at: <https://www.gov.scot/publications/maximising-recovery-promoting-independence-intermediate-care-framework-scotland/> (Accessed 5 May 2021).

Capacity to consent to the move

What we expected to find

The law recognises that each of us, as adults, has the right to make decisions for ourselves unless it is established that we lack the capacity to do so. There was no change to this law during the pandemic.

An individual may have difficulties communicating or expressing their views verbally, but this does not mean they necessarily lack the capacity to hold a view.⁹ A person's capacity should be assumed unless there is evidence, despite individualised support, that they are unable to make informed decisions.¹⁰ Capacity/incapacity is not all or nothing, it is decision specific, therefore it is important when decisions are needing to be made that it is clear in what areas the individual has capacity.

In 2019, Health and Social Care Integration, Scottish Government, produced the guide *Discharging Adults with Incapacity* which refers to what must be considered at the assessment stage if any concerns regarding capacity are raised.¹¹ It confirms that the individual should be referred to an appropriate clinician for a formal assessment of capacity.

We would expect that the matter of capacity to decide and agree to a move to a care home is fully considered in partnership with all adults being discharged from hospital to care homes. Where the medical assessment confirms that an adult does not have the capacity to agree to such a move, the existing legal framework should be taken into account and implemented to ensure appropriate safeguards and respect for the person's rights; human rights and social, cultural and economic rights.

What we found

Out of the 457 cases, we were told that 437 people (96%) lacked capacity and for the remaining 20 cases (4%) we were told capacity was unclear.

We found some good practice. For example, we were told of written letters on file from medical professionals confirming assessed incapacity. We also found clear recording in information systems detailing outcomes of capacity assessments and dates. However, this was not consistent across and within HSCP areas.

We were advised that it was difficult in some areas to get formal assessments of capacity carried out during the first three months of the pandemic due to other competing demands within the hospital, and that extracts from medical records were at times used to ascertain incapacity.

HSCPs advised that there was often a lack of clarity about who assessed that the person lacked capacity and when this assessment was carried out in relation to the person's ability to consent to a move to a care home. They reported that there is little in the way of guidance

⁹ Mental Welfare Commission for Scotland. (2020). Working with the Adults with Incapacity Act – for people working in adult care settings. Available at: https://www.mwscot.org.uk/sites/default/files/2020-08/WorkingWithAWI_June2020.pdf (Accessed 5 May 2021).

¹⁰ Mental Welfare Commission for Scotland. (2021). *Supported decision making*. Available at: <https://www.mwscot.org.uk/sites/default/files/2021-02/Supported%20Decision%20Making%202021.pdf> (Accessed 5 May 2021).

¹¹ Scottish Government. (2019). *Discharging Adults who lack capacity*. Available at: <https://hscscotland.scot/couch/uploads/file/planning-discharge-from-hospital-adults-with-incapacity-march-2019.pdf> (Accessed 5 May 2021).

regarding how and where incapacity is reported or recorded in practice. We were particularly concerned to hear them say that incapacity had, at times, just “been assumed”.

Additionally we were given examples of where the practitioner did not consider it necessary to consider the person’s capacity to decide on a move to a care home as a Power of Attorney (PoA) was in place. A PoA is granted at a point where the granter has capacity. It becomes operational only when the granter loses capacity. The existence of a PoA is therefore no indicator of incapacity and confirmation of incapacity is crucial for this legal authority to become valid.

In some cases where HSCPs had advised that the individual lacked capacity there appeared to be a degree of confusion as the HSCPs also reported that there was no need for legal intervention as the person had consented to the move. As discussed earlier, capacity is not an all or nothing concept and we would expect an assessment to be conducted specific to the individual’s ability to make decisions about where they live and the type of care they receive. Lack of resistance to a proposed care plan should not be equated with consent.

Finally, there appeared to be a degree of confusion within HSCPs around terminology and the use of different parts of the AWI Act. For example, we heard consistently from HSCPs that an “AWI was in place” and that this therefore provided the legal authority for the move to a care home. On further analysis this would appear to have been a s.47 certificate which relates to decisions about medical treatment under Part 5 of the AWI Act. While this certificate is granted following an assessment of the individual’s incapacity to consent to medical treatment, the authority of this certificate does not extend to decisions in relation to a significant move to a registered care setting with 24-hour supervision at all times.

Deprivation of liberty

What we expected to find

In 2014, the Mental Welfare Commission published an advice note in relation to the UK Supreme Court's view on the definition of deprivation of liberty (known as Cheshire West).¹²

The Supreme Court ruling states that deprivation of liberty is a matter of fact and does not depend on the purpose of the intervention or the nature of the person's individual circumstances. The majority of the judges agreed that the fundamental characteristics of deprivation of liberty are being "under continuous supervision and control" and "lack of freedom to leave".¹³

The Commission's advice note was clear that services should operate within the existing Scottish statutory framework, and be informed by this case law. What this means in practice is that if services are satisfied that a person who cannot consent will be deprived of their liberty, using the Cheshire West definition, then it is necessary to consider and record what lawful authority justifies that detention; not to do so is potentially a violation of a person's right to liberty.

This 2014 advice note remains relevant to date and we would expect that practitioners involved in arranging discharges from hospital and admissions to care homes would be familiar with this definition and the need for appropriate intervention to address any instances of deprivation of liberty they encounter. It is also important to note that extended unnecessary stays in hospital can also constitute a deprivation of liberty.

As part of this project we wanted to review how embedded understanding of deprivation of liberty was in practice.

What we found

Within the cases we sampled we felt that all the placements, including those termed 'interim or temporary' potentially represented a deprivation of liberty for the adults who lacked capacity, thereby engaging Article 5 of the European Convention on Human Rights (ECHR) (the right to liberty); this was not a view consistently shared by practitioners however.

Within the sample, 10% of practitioners did not believe that the placement constituted a deprivation of liberty, despite involving continuous supervision of the individual and a lack of freedom to leave the care home voluntarily (for example, keypad exit/entry systems where the numbers were not shared with residents). Some explained their view that the assessed need for this level of care, and the risks to the adult without this level of care, negated this definition.

We found a lack of knowledge of the Cheshire West ruling and a lack of understanding that intention to act in the best interests may potentially be discriminatory and prevent those most vulnerable from their right to access legal and procedural safeguards.

We noted that some HSCPs explained that they were not always sure about what constituted a deprivation of liberty and were keen to receive further advice and guidance on this subject.

¹² Mental Welfare Commission. (2014). *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision*
https://www.mwscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf (Accessed 5 May 2021).

¹³ Mental Welfare Commission. (2014). *Mental Welfare Commission response to queries related to when to use s13ZA v Guardianship following the Cheshire West Supreme Court decision*
https://www.mwscot.org.uk/sites/default/files/2019-07/cheshire_west_draft_guidance.pdf (Accessed 5 May 2021).

Where areas had deployed mental health officers to support discharge planning processes this additional expertise was welcomed. It was also suggested that those involved in discharge planning were under significant pressure to manage delayed discharges, which felt like a process of "emptying beds" and it was a "battle" to retain focus on the person. Whilst this was exemplified by the pandemic, it was explained that the pressures relating to delayed discharge processes have been long standing and challenging.

Without understanding of what may constitute a deprivation of liberty, practice may well be flawed, with consequent impact on the rights of the individual who lacks capacity. Discharges from hospital to care homes bring this into sharp focus and practitioners require high levels of training, support and leadership to fulfil their functions to ensure that any moves are lawful and compliant with an individual's human rights, as well as their economic, social and cultural rights.

Legal framework for the moves

Within our sample, we were told that 74% of the moves that took place (involving people assessed as lacking capacity to decide on a care home move) were underpinned by the legal authority of a Welfare Guardianship Order or the existence of a Welfare Power of Attorney (hereafter 'WG/PoA'). Twenty percent of moves were reported under s.13ZA of the Social Work (Scotland) Act 1968 and two per cent under other legal frameworks, namely compulsory treatment orders under the Mental Health (Care and Treatment)(Scotland) Act 2003.

From the information we received there were 20 cases (4%) where no legal framework had been in place to facilitate the commissioning of the care home placement for the individual.

Whilst we welcomed the information provided by HSCPs, further analysis of the detail would suggest that not all the moves reported met the criteria for the legal framework we were told about.

Geographical differences in legal authority used

An overview of what legal frameworks were used in each HSCP is presented in Table 3. A dot indicates that we identified moves under that legal framework within the HSCP. Due to the small numbers in many areas, we have not published them here.

We found from the information we received that moves had happened without legal authority in 11 of the 30 HSCPs (37%) that we looked at, ranging from 3% of all moves in one area to 100% of all moves in one area. S.13ZA had been used in 23 (76%) of HSCPs, which ranging 8–36% of all moves. In 14 of these HSCPs (61%), the percent of moves under s.13ZA was higher than the overall average of 20%.

This information, however, is a reflection of the information we were provided by HSCPs. In the next sections we describe what we found when we looked into cases in more detail.

Table 3. Reported legal authorities used for moves by HSCP

HSCP	13za	No legal authority	WG/POA
Aberdeen City	•	•	•
Aberdeenshire	•	•	•
Angus	•		•
Argyll and Bute	•	•	•
Borders	•	•	•
Dumfries and Galloway	•		•
Dundee	•		•
East Ayrshire	•		•
East Dunbartonshire			•
East Lothian	•		•
East Renfrewshire	•		•
Edinburgh	•	•	•
Falkirk	•		•
Fife	•		•
Glasgow City	•		•
Inverclyde	•		•
Midlothian	•		•
Moray		•	•
North Ayrshire	•	•	•
North Lanarkshire	•	•	•
Orkney		•	
Perth and Kinross	•		•
Renfrewshire			•
Shetland		•	•
South Ayrshire			•
South Lanarkshire	•		•
Stirling and Clackmannanshire	•		•
West Dunbartonshire	•		•
West Lothian	•	•	•
Western Isles			•

Note that Highland did not provide information requested within the timescale required for this report and is therefore not represented here

Welfare guardianship orders/Power of Attorney

Of all 457 moves, 338 were reported to have been authorised by either Welfare PoAs (79%) or Welfare Guardianship Orders (21%).

Power of Attorney

What we expected to find

When someone makes a power of attorney (PoA) they appoint someone else to act on their behalf. The person making the PoA is called the granter and the person appointed to act on their behalf is called an attorney.

A PoA gives the attorney the legal authority to deal with financial/property matters (financial or continuing PoA) and/or personal welfare (welfare PoA).

- Powers relating to the granter's financial/property affairs are known as 'continuing or financial powers and may be given either with the intention of taking effect immediately and continuing upon the granter's incapacity, or to begin on the incapacity of the granter.
- Powers relating to the granter's welfare are known as welfare powers and cannot be exercised until the granter has lost the capacity to make these decisions.

A PoA is drawn up when the granter has the mental capacity to do so.

Following a number of publicity drives over the past few years to raise awareness about Powers of Attorney, there has been a rise in the number of PoAs registered with the Office of the Public Guardian (OPG).

Table 4. Number of PoAs registered, by year

Year	Number registered
2017-18	2,966
2018-19	2,975
2019-20	4,706
2020-21	6788

Source: Office for the Public Guardian¹⁴

The PoA can only be used when registered with the OPG and the attorney should provide a certificated copy of the document to relevant parties to confirm their status as attorney.

A PoA that is to begin in the event of incapacity should have a statement confirming that the granter 'has considered how their incapacity is to be determined' and HSCP staff using a PoA as legal authority for welfare decisions must be satisfied that incapacity has been confirmed according to this statement.

Where an attorney is stating that they are acting as attorney, they should be expected to produce the certificated PoA document that has been registered with the OPG. Relatives, on occasion, may refer to themselves as having PoA when they are in fact the person's appointee for Department of Work and Pensions benefits, or they are simply the next of kin. It is important to clarify and ensure a shared understanding.

¹⁴ Office of the Public Guardian. (2021). *Expedited Powers of Attorney* [online] available at: <https://www.publicguardian-scotland.gov.uk/general/about-us/performance/power-of-attorney-performance-2020-2021> (Accessed 20 April 2021).

Whilst it is important that consultation with relevant others takes place at times of key decisions it must be remembered that it is only a welfare PoA or a welfare guardian who would have the legal authority to make welfare decisions for an adult who has lost capacity to do so.

It is therefore vital that services ask for a copy of the PoA document to ensure that it has been registered with the OPG, to check what the powers are, and to confirm how the granter wants their incapacity determined.

For instance, where it states that the PoA requires to be triggered by a written medical statement of incapacity, this should be provided along with a copy of the PoA document. It is important that staff read the PoA document with regard to the powers and any stipulation about when the attorney can act, particularly where there are contentious decisions.

What we found

Within the cases we sampled we were told that the most prevalent legal authority used to authorise a move from hospital to a care home, was a welfare PoA, with 267 moves reported to be authorised by this legal authority.

However, in a number of cases where the HSCP advised that a PoA had provided the legal authority for the move, further analysis suggested that the validity of this legal authority was not always established.

We asked when the PoA which was authorising the move was granted, and in 70 cases this information was either unknown or not recorded.

Where a PoA was the reported legal authority for the move from hospital to care home, we asked if the powers had been triggered in accordance with the clause or “trigger” in the individual’s document which stipulated how incapacity would be established. Seventy seven out of 267 confirmed they were unclear if the powers had been validly triggered, while the remainder confirmed that powers were triggered. Within this remaining 190 who confirmed that powers were triggered, 33 of these had no record of how, when or by whom incapacity had been assessed so it was difficult to state with confidence that these powers had, in fact, been triggered in line with the requirements of the PoA document.

We heard in some instances that incapacity had been confirmed as evidenced by an “AWI” being in place, however, as we discussed earlier, further analysis evidenced that this would appear to have been a s.47 certificate which authorises treatment for an adult who is incapable of consenting to the particular treatment. Although this may be an indicator of cognitive impairment in relation to treatment decision making, it does not equate to an assessment of incapacity to trigger a PoA.

We found in 78 of the cases where PoA was believed to be the legal authority for the move, HSCP practitioners reported that they had not read the PoA document. A further 61 reported that they had either read the document or had been advised of the contents of the document but had not recorded any of the details on records.

We asked if there was a power included in the document which authorised decision making in relation to where the granter should live. HSCPs advised that in 231 cases there was a relevant power. However given the number of instances where the documents were either unavailable or had not been seen, it is difficult to understand how this information had been ascertained other than reports that HSCPs had assumed the existence of this power as it is a standard power contained in most PoA documents.

There were examples within the sample where PoA was cited as the legal authority for the move but on further examination was found not to be the case, for example, where the powers related only to financial decisions or where the PoA had not been registered with the OPG. This highlights the requirement for HSCPs to seek a copy of the certified PoA document to inform their intervention and for a record of the validity of this authority to act on the granter's behalf.

The landscape in which these discharges from hospital were managed was complex due to the distanced working arrangements in response to pandemic restrictions which resulted in for example, social work staff not having access to the wards, medical notes or in many cases the patient themselves. We acknowledge the complexities which were in place at this time but it is unclear if these omissions were as a result of these restricted working arrangements or indeed arose as a result of a lack of understanding for some staff effecting hospital discharges about the different elements of what constitutes a legal proxy decision maker and the scope and limitations contained within individual documents.

Recording may well have been a significant issue in HSCP practitioners accurately reflecting retrospectively on individual circumstances when approached by us as part of this piece of work. In some instances the recording of relevant information was incomplete and at times absent, leaving practitioners in doubt about the circumstances around individual discharges. One example related to a care team recognising the limitations of a PoA given the persistent opposition of the person with incapacity to the move to a care home. The recorded recommendation was to apply for an interim guardianship order to ensure appropriate safeguards and to facilitate the move. Records were subsequently absent, and the key contact had assumed that the interim order had been granted. Further analysis confirmed no order had in fact been applied for, yet the move had taken place.

HSCP staff are bound by professional codes of practice which require clear, accurate and up to date record keeping – it is difficult to ascertain if these deficits in recording were as a result of the pressures staff were under including their restricted access to information systems at the time (due to home working) but it is clear that evidencing legal authority for a number of moves was compromised as a result.

It is important to note that practice varied across Scotland. In some areas good practice was clearly evidenced where a copy of the PoA document was accessible within records, there was clarity about what was required to activate the powers, a clear record of when an assessment of incapacity had been completed and by whom and the presence of a power to decide where the adult should live.

Welfare Guardianship

What we expected to find

Guardianship under the AWI Act is a legal process that allows relatives/carers or other parties, such as local authorities, to make certain decisions or take certain actions regarding the welfare or financial affairs of adults who are assessed as lacking capacity to make these decisions themselves.

Adults mean anyone over the age of 16 years. One of the primary uses of welfare guardianship under the AWI Act is to authorise not just where a person should live, but also the care he or she should receive, and how this is delivered. The powers granted relate to those areas of a person's life in which he or she lacks the capacity to make decisions or take actions which need to be made or taken to safeguard their rights and protect their welfare.

A welfare guardian is appointed by the court to make specific welfare decisions on behalf of an individual who does not have capacity to make decisions him or herself.

The expectation is that the welfare guardian should give a copy of the order granted to relevant professionals and care/support staff. This will ensure that all relevant parties involved in the individual's care know which powers have been authorised on behalf of the individual. The order should be kept on file so that it is accessible to staff who are providing day-to-day care for the individual. The decisions the guardian can make will be specified in the guardianship order. A guardian may have the legal authority to make a number of decisions on behalf of an adult who lacks the capacity to make these decisions for him or herself. However, presumption should not be made that the guardian has the power to make all decisions about the care of the individual and it is important that practitioners check that the guardian has the power to consent to the required decisions about the person's care home placement.

When a welfare guardian (or a PoA) is making decisions, they must adhere to the principles of the AWI Act at all times. These principles include:

- Any action or decision taken must benefit the adult and only be taken when that benefit cannot reasonably be achieved without it.
- Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.
- Account shall be taken of the present and past wishes and feelings of the adult, as far as they can be ascertained.
- Where practicable, they should take the views of relevant others into account.
- They must encourage the individual to use existing skills and gain new skills. This includes helping the individual to exercise any capacity he/she has to make choices concerning their property, financial affairs and their personal welfare.

Where a guardian requires to make the decision about moving to a care home on behalf of the adult, the guardian must have the necessary power in place to authorise this and must take into account the individual's views, both past and present.

What we found

We wanted to know how many people were subject to a welfare guardianship order which legally authorised the move to a care home. We found that, in our sample, welfare guardianship orders were granted prior to the move for 71 individuals who moved to a care home.

All of these individuals had a specific power authorising the adult to move to the care home. Guardianship orders in place were a mixture of private and local authority welfare guardians.

Some of the orders granted by the court included interim powers and had specific powers that gave authority to facilitate the move for the individual before the full guardianship order was granted. An interim order is time limited until a full hearing can take place in court.

An example in one HSCP showed that interim guardianship powers were granted to the chief social work officer (CSWO) in March 2020. This included the specific power to facilitate the move for the person from hospital to a care home with the full suite of powers subsequently granted to the CSWO.

When an application is lodged in court, interim orders can be requested at that specific time, and the sheriff will consider the necessity of such interim powers. Interim orders can expedite a legally authorised discharge from hospital for an individual who lacks capacity to consent to the move.

We were told about some guardianship applications that had been lodged in court however - due to the pandemic - the applications were not heard and had been put on hold. We also heard of instances where a HSCP reviewed the decision to apply for a welfare guardianship order and revisited legal authority for the move as the individual reportedly satisfied the criteria for other authorisation e.g. initially the HSCP concluded that an application for welfare guardianship was required, but on review felt that the individual met the criteria to be moved under s.13ZA.

We also found that there were cases where the HSCP believed that an order was in place at the time of the move however further inquiry confirmed that the order was not in fact granted until the courts re-opened, that is, after the person had moved to the care home. This confusion during the pandemic period led to the individual being moved unlawfully.

In line with earlier discussion around PoA, HSCP practitioners implementing a hospital discharge for an adult who lacks capacity to consent should seek evidence of the legal guardianship powers that they intend to use to effect the discharge. Without this, there is the potential that people can be moved without due legal authority and have their rights significantly compromised.

Section 13ZA of the Social Work (Scotland) Act 1968

What we expected to find

S.13ZA took effect in March 2007. It is a legal framework which allows a local authority to make significant care arrangements, under the powers of the Social Work (Scotland) Act 1968, where the person is not capable of making decisions about receipt of a service. The conditions state that there must be no existing proxy decision maker with relevant authority and there is no application for an order under the AWI Act with relevant powers in the process of being determined.

Intervention under s.13ZA may be appropriate where an adult does not indicate disagreement with the proposed action, either verbally or through their behaviour/actions, and it appears that they are likely to accept the care arrangements. All interested parties, including professionals and the person's family/carer must agree with the care intervention proposed.

In 2007 the Scottish Executive issued guidance to local authorities on their powers under the 1968 Act.¹⁵ In 2014 we, the Commission, confirmed our view that what was good practice before the Cheshire West case will, in large part, remain good practice (pending any legislative change by the Scottish Government), but that the Cheshire West decision makes it even more necessary that there is a proper and auditable process for taking decisions on care arrangements for people who lack capacity, and that this process fully reflects the principles of the AWI Act.¹⁶

We therefore expected to find some moves made according to s.13ZA of the Social Work (Scotland) Act 1968 within our sample, with clear auditable processes detailing the basis of decision making.

The Coronavirus (Scotland) Act received Royal Assent on 6 April 2020 and the Commission noted the significant changes to how s.13ZA might operate under emergency powers in this Act. The Scottish Government agreed that the Commission would play a key role in ensuring a transparent scrutiny process if these emergency powers (also known as the easements to s.13ZA) were introduced, to prevent any abuse of these emergency powers.

The Scottish Government subsequently confirmed that even at the height of the pandemic "the fine balance between the right to life and the right to be consulted was not such that the provisions should be brought into force".¹⁷ Easement of s.13ZA was therefore never introduced and on 29 September 2020 the provisions expired through The Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020.

We therefore did not expect to find any moves to have been made based on emergency powers linked to the Coronavirus (Scotland) Act given this legislation was not enacted and no cases were brought to the Commission's attention for scrutiny as per agreed process.

¹⁵ Scottish Executive. (2007). *Guidance for local authorities: provision of community care services to adults with incapacity*. Available at: http://www.sehd.scot.nhs.uk/publications/CC2007_05.pdf (Accessed 5 May 2021).

¹⁶ Mental Welfare Commission (2020). *Working with the Adults with Incapacity Act for people in adult care settings*. Available at <https://www.mwscot.org.uk/node/1480> (Accessed 5 May 2021)

¹⁷ Scottish Government (2020). Coronavirus (COVID-19): adults with incapacity guidance. Available at: <https://www.gov.scot/publications/coronavirus-covid-19-adults-with-incapacity-guidance/> (Accessed 5 May 2021).

What we found

We were told that s.13ZA authorised 90 moves (20%) from hospital to care home in our sample. Whilst we were told that the majority of individuals who moved had their capacity assessed and this was confirmed by a doctor, we were told for some cases that it was unclear when the capacity assessment was conducted, but that it was recorded in the notes that the adult “lacks capacity”. Other discussions with key contacts concluded that there was no evidence written in the record about the person’s capacity, whilst we were told for some that “an AWI” was in place as discussed earlier, again evidencing confusion around understanding of this.

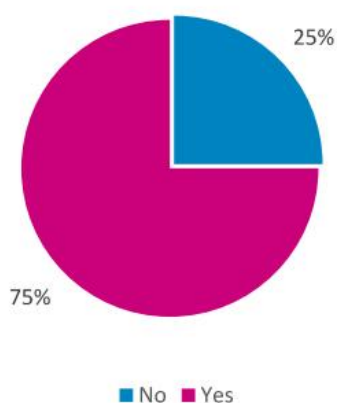
For a move to be authorised by applying s.13ZA, an adult must be incapable of making decisions about where they wish to live. If incapacity is not clear then this should be determined, following full support to maximise the person’s participation in the decision making and should not be assumed.

The 2007 Scottish Executive guidance¹⁸ highlights the requirements and processes to use when considering the use of s.13ZA as a legal framework. This includes who should be involved in discussions and what format these should take. The Scottish Executive confirmed that the views of all involved parties are important and therefore a record of the discussions and decisions reached should be maintained. As stated previously, in 2014, the Commission confirmed that Cheshire West reinforced the importance of auditable decision making processes in relation to safeguarding adults who are assessed as lacking capacity to decide on their care and support.

We found that in 70 of the cases where s.13ZA had been used (75%), a case conference and/or case discussion had taken place. Minutes of the discussion/conference were available in 60% (n=42) of these cases.

In 63% of cases where a discussion or conference had taken place, a mental health officer (MHO) had been involved, while in 33% no MHO had been involved and in 4% of cases it was unclear whether this had been the case. We heard of areas where MHOs operate within the hospital discharge teams and are involved in the majority of AWI Act/s.13ZA case conferences/discussions and this provided an additional safeguard to ensure decisions taken were compliant with legislation, rights and good practice.

Figure 2. Percent of s.13ZA cases where a case conference and/or case discussion took place



¹⁸ Scottish Executive, *Guidance for local authorities*

In the 25% (n=20) where neither a case conference nor a case discussion had taken place, we were told that there was a record of the decision to use s.13ZA in 80% (n=16) of the cases. In the remaining four cases there was either no record of the decision or it was unclear if there was a record.

We also wanted to know if the principles of the AWI Act had been applied in cases where s.13ZA had been used. We were told that in 86% of cases (n=77) where s.13ZA had been used there was evidence that the principles of the AWI Act had been applied. However, in 10% of cases we found no evidence that this was the case and in four cases (4%) information was not provided.

We were told that due to the pandemic restrictions, most discussions/meetings took place virtually and often involved the key contact gathering the views from individuals separately due to restrictions in place and no access to wards.

We noted that individuals who lacked capacity and should have been at the centre of this process were not always seen and while we acknowledge the restrictions which were in place at this critical time of the pandemic, some areas did achieve inclusion while in other areas it seemed a fundamental omission.

We viewed some records as part of this project and saw that record of views and minutes of meetings were clear, concise and documented reasons why s.13ZA was applicable. For example:

In Area W there were two instances when s.13ZA had been used as the legal authority to effect a transfer from hospital to a care home. Both of these were well documented on a system which was an embedded process in their IT system to ensure the relevant letters are sent to families and relevant people in the process; also decision making invoking 13ZA powers was well recorded. The two patients reviewed also had involvement from advocacy.

However, this was not always the case. We also had access to records where not all views were gathered and there was lack of detail regarding decision making and legal process. For example:

No record of case conference or case discussion-there was a record of decision that says principles were not applied. Record in social work information system that individual was moved under s.13ZA - no record of who was involved in this decision.

The adult's family were involved in the discharge decision making process. MHO and SW visited ward. There is a case note indicating that the doctor had confirmed that the person could move under s.13ZA but there was no record of a meeting/minute/manager decision. Son and daughter both involved in moving to care home. No evidence of s.13ZA being properly used according to SW officer. There was a 13ZA pro-forma used but no details could be found by the social worker as the process had not been followed....

We also found occasions where s.13ZA appeared to be used inappropriately:

S.13ZA was used to move this person, however the service user dissented They moved to a permanent placement and are still in the care home. The record of views meeting shows that the service user did not agree to a move to a care home. The opposition (from the person) is described as 'soft' and due to Covid risks a 'liberal' application of 13ZA was used.

We heard from HSCPs that some areas believed that emergency legislation had in fact been implemented and that this revised version of s.13ZA had provided legal authority for some moves. For example:

Some staff were of the understanding that emergency legislation had been enacted and as such views did not have to be taken in account. There appears to have been an e-mail from their legal department to this effect.

When section 13ZA was inserted in the Social Work Scotland Act in 2007 the intention was for the Social Work Inspection Agency to “from time to time, examine case records in relation to the application of this guidance and the use made of s.13ZA of the 1968 Act”.¹⁹ The health and social care landscape has evolved and changed considerably since 2007 and to date, this monitoring role has not been implemented.

¹⁹ Scottish Executive, *Guidance for local authorities*

No legal authority

What we expected to find

Given the existing guidance, policy and legislation, including the Coronavirus (Scotland) Act 2020, we did not expect to find people, assessed as lacking capacity, being moved without legal authority from hospitals to care homes during the sample period.

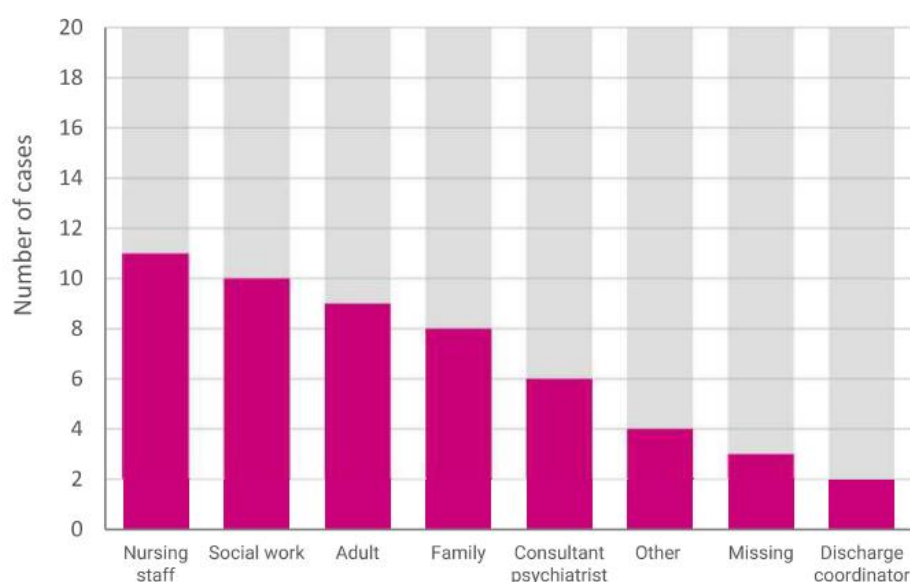
What we found

Within the data we collected, HSCPs identified 20 cases (4%) where no legal authority had been considered or been put in place to authorise the move. We wanted to explore who had been consulted about the move in these cases. Figure 3 shows that nursing staff were primarily consulted and social work staff were consulted in half of the cases. We were told that the adult who was subject to the move was consulted in only nine out of the 20 cases. Eleven people were moved without any consultation with them. There also appeared to be a lack of consultation with family and consultant psychiatrists in most cases, and a discharge coordinator had been consulted in two of the 20 cases.

Given the information received from HSCPs that these discharges had not been legally authorised we wanted to know if other important parts of the discharge process had been followed.

We looked at whether a social work assessment (SWA) had been undertaken in these cases. We found that in 18 cases a SWA had been done, a copy of the assessment was available for 16 of these cases. For the two cases where no SWA had been done, the notes indicated that an assessment had been done before the admission to hospital which recommended a package of care at home and had not been updated and for the other was because social work had not been involved in the move.

Figure 3. Individuals consulted about the move



Note that these categories are not mutually exclusive

We asked how these placements were funded and were advised that funding was in place for 18 of the 20 individuals who were moved without legal authority, the majority (n=15) were local

authority funded and the remaining three were self-funded. For the two individuals who did not have funding in place we noted the following:

Funding for Person L was agreed by local authority on [date] but backdated to the date of admission to the care home.

It was viewed by the HSCP practitioner as transitional care from NHS to NHS and social work services were not involved at this time. However, on checking this out further [name of care home] is not a NHS facility.

This data in relation to people who were moved with no legal authority is based on the information reported by HSCPs during the data collection stage of this project and relates to 20 people across 11 HSCPs out of a sample of 457. Although Highland HSCP did not provide information in time for use in this report, they did provide information suggesting that, like other HSCPs, moves may have been made there without appropriate legal authority too.

It is important to note that the reality, as described throughout this report, evidences a more worrying picture with regards to the legal authority used to facilitate moves. HSCP practitioners involved at the heart of the hospital discharge process consistently reported the use of what they believed to be a valid legal authority which, following further analysis, was not always the case.

This lack of clarity and understanding about the validity, scope and limitations of the use of legislation, has the potential to leave our most vulnerable adults at risk of their rights not being upheld and being detained unlawfully in care settings.

Summary of findings

We made contact in relation to 731 people who had moved from a hospital to a care home during the period 1 March 2020 to 31 May 2020. From the information reported, we looked further into 457 cases where the individual lacked capacity to engage in decision making around the plan to arrange 24-hour care in a care home setting for them.

We found evidence of some good practice, for example:

- Commitment to ensure that what mattered to the individual was central to outcomes and decisions made on their behalf
- Commitment to ensure that all efforts were made to ensure that the individual was supported to inform decision making where possible, including advocacy support and multiple direct contacts with the individual
- Respect for multidisciplinary roles and responsibilities ensuring that health and social care/social work retained focus on individuals and not other drivers such as beds and finance.
- Embedding the role of the MHO in discharge planning processes as a key safeguard with expertise and focus on the rights of individuals.
- Clear understanding of the requirement to ensure that reported powers under the AWI Act/PoA are activated, evidenced and referred to in practice.
- Interim guardianship powers sought, where appropriate, to effect timely and lawful hospital discharge.
- Increasing promotion and take up of PoA roles and responsibilities.

However, we found that practice was not consistent either within some HSCPs or across HSCPS. This is despite a range of existing guidance, policy and local arrangements to support implementation.

Some of our findings were specifically related to the pandemic. For example, we found some evidence that there had been an interpretation that easement of s.13ZA had been enacted as a result of the Coronavirus (Scotland) Act 2020 when in fact this legislation was never activated and indeed removed in September 2020. Although Highland HSCP did not provide us with information requested within timescale to fully inform this report, they did advise that they introduced an alternative to application for an AWI order, making decisions 'internally' rather than recourse to the courts, the critical safeguard for individuals. This particular practice started in response to the pandemic and ended in August 2020.

The Commission's significant concern is that, in these cases, this may present as not only lacking in clear legal authority but also as an Article 5 deprivation of liberty and a possible breach of ECHR. The Commission does not provide legal advice so we asked whether legal advice had been sought in relation to both of these practices; confirmation was given that legal advice had been sought and given.

Section 13ZA of the Social Work (Scotland) Act 1968 was reportedly used to authorise moves in 23 Health and Social Care Partnerships and either Welfare Power of Attorney or Welfare Guardianship was used to authorise moves across 30 of the 31 Health and Social Care Partnerships.

We took further steps to assure legal rights were respected and protected beyond the 20 unlawful moves reported and found that those working in the field of hospital discharge were

not always fully sighted on the powers held by attorneys or guardians or indeed whether the attorney's powers had been activated or guardianship orders granted. It is our view that such assumptions, rather than evidence based decision making, had the potential to render additional moves as unlawful and also as an Article 5 deprivation of liberty and a possible breach of ECHR.

We also found confusion in relation to the reported nature of the care home placement with potential impact on rights to protection of property where the person was admitted to a care home but remained liable for their property.

Evidence of poor recording practice made it difficult for HSCPs to answer some of our queries despite their best efforts to do so.

In summary, whilst we identified good areas of practice across HSCPs in Scotland we also identified significant areas of learning and improvement required. Whilst the pandemic brought unprecedented pressures to bear on HSCPs, the identified areas for improvement arising from our examination of a sample number of hospital to care homes moves, are not exclusively as a result of the pandemic. Indeed, our findings evidence longer standing systemic issues within HSCPS which require urgent action in order to safeguard and uphold the rights of the most vulnerable adults in our society. To this end, we have made eleven recommendations that we hope will assist HSCPs.

Recommendations

Based on our findings we recommend the following areas for improvement:

Recommendation 1: HSCPs should undertake a full training needs analysis to identify gaps in knowledge in relation to capacity and assessment, associated legislation, deprivation of liberty definition and the human rights of individuals (as detailed in this report) to inform delivery of training programmes to ensure a confident, competent, multidisciplinary workforce supporting safe and lawful hospital discharge planning.

Recommendation 2: HSCPs should establish a consistent system for recording when an assessment of incapacity has been conducted, by whom and in relation to which areas of decision making.

Recommendation 3: HSCPs should ensure that staff facilitating hospital discharges are clear about the status of registered care home placements, in terms of law (see EHRC vs GGC)²⁰ and with regards the financial and welfare implications of different types of placements for the individual.

Recommendation 4: HSCPs should ensure that practitioners facilitating hospital discharges have copies of relevant documents on file detailing the powers as evidence for taking action on behalf of the individual who is assessed as lacking capacity.

Recommendation 5: HSCPs should ensure that assessments reflect the person as a unique individual with focus on outcomes important to that individual and not external drivers that have the potential to compromise human rights and/or legality of moves.

Recommendation 6: HSCPs should ensure that processes are in place to audit recording of decisions and the legality of hospital discharges for adults who lack capacity in line with existing guidance and the principles of incapacity legislation.

Recommendation 7: HSCPs' audit processes should extend to ensuring evidence of practice that is inclusive, maximising contribution by the individual and their relevant others, specifically carers as per section 28 Carers (Scotland) Act 2016.

Recommendation 8: HSCPs should ensure strong leadership and expertise to support operational discharge teams.

Recommendation 9: The Care Inspectorate should take account of the findings of this report regarding the use of s.13ZA of the Social Work (Scotland) Act 1968 and consider the scrutiny, assurance or improvement activity to take in relation to this.

Recommendation 10: The Care Inspectorate should take account of the broader findings of this report beyond use of s.13ZA and consider how this might inform future scrutiny, assurance and improvement activity in services for adults.

Recommendation 11: The Scottish Government should monitor the delivery of the above recommendations and work with Health and Social Care Partnerships and the Care Inspectorate to support consistency and address any barriers to delivery over the next two years.

²⁰ Equality and Human Rights Commission (2020). Equality and Human Rights Commission reaches settlement

Conclusion

This piece of work aimed to explore, within a 10% sample of all moves reported, whether there were any unlawful moves of individuals from hospital into care homes during the early stages of the pandemic. Our sample size was small hence we expected any learning or outcomes to be indicative rather than definitive, that is, if we found unlawful moves in one area that would not necessarily mean that all moves had been unlawful in that area, similarly, if we found no unlawful moves in another area, that did not necessarily mean there had been no unlawful moves there.

Twenty unlawful moves, across eleven Health and Social Care Partnership areas, were reported directly to us. Further analysis suggested that there may have been more unlawful moves than reported. For example, within Health and Social Care Partnerships we found a general lack of understanding of the law used to provide legal authority to facilitate moves from hospital to care homes. We also found assumptions were made about whether legal powers were in fact in place.

When we set out to undertake this report we intended to make inquiries in relation to how the law was used to protect the most vulnerable adults in our community during the significant challenges of the pandemic period. During the course of this work we found examples of poor practice and a lack of knowledge of the law that were presented as more longstanding and endemic.

We will be contacting individual Health and Social Care Partnerships to highlight both good areas of practice and areas of practice which fall short. However we call on all Health and Social Care Partnerships to take urgent action now in relation to the 11 recommendations made in this report to develop both a supported, competent, confident workforce and local auditable processes to ensure implementation of good practice. We also ask the Care Inspectorate, the responsible regulatory body, to incorporate the findings of this report in their inspection activity.

Glossary

CSWO	Chief Social Work Officer. The Social Work (Scotland) Act 1968 requires local authorities to appoint a single Chief Social Work Officer (CSWO) for the purposes of listed social work functions. The role provides a strategic and professional leadership role in the delivery of social work services.
ECHR	European Convention on Human Rights
EHRC	Equality and Human Rights Commission
HSCP	Health and Social Care Partnership. A Health and Social Care Partnership is not a separate organisation distinct from the council or the health board. The term Health and Social Care Partnership or HSCP refers to the joint operational arrangements that exist in a council area between the council social work services and the health care services of the local health board. All clinical, professional and support staff who work within a HSCP are employed by the health board or the council in the specific geographical area.
Key contact	An identified member of staff from the HSCP who was able to provide information about the hospital discharge
MHO	Mental Health Officer. Mental Health Officers are social workers with a minimum of two years post qualifying experience who have gained the Mental Health Officer Award (MHOA), which prepares experienced social workers to undertake the statutory role defined by the AWI Act and the Mental Health (Care and Treatment)(Scotland) Act 2003.
PHS	Public Health Scotland
PoA	Power of Attorney – someone appointed by a person with capacity to make decisions about their welfare in the event that they lose capacity to do so themselves
OPG	The Office of the Public Guardian in Scotland was created when the Adults with Incapacity (Scotland) Act 2000 received Royal Assent. It is a single information point about financial provisions contained in the Act.
s.47	Section 47 (AWI) Certificate issued by a doctor where the adult cannot consent to the treatment being given.
Welfare Guardian	A person appointed by the Sheriff Court to make decisions in relation to the welfare of a person who has been assessed as lacking capacity to make these decisions themselves.

Legislation

- Adults with Incapacity (Scotland) Act 2000
- Coronavirus (Scotland) Act 2020
- Social Work (Scotland) Act 1968
- Carers (Scotland) Act 2016
- Mental Health (Care and Treatment)(Scotland) Act 2003
- The Coronavirus (Scotland) Acts (Early Expiry of Provisions) Regulations 2020

Links

- Equality and Human Rights Commission (2020). *Equality and Human Rights Commission reaches settlement on ending unlawful detention of adults with incapacity by NHS Greater Glasgow and Clyde* [online] Available at: <https://www.equalityhumanrights.com/en/our-work/news/equality-and-human-rights-commission-reaches-settlement-ending-unlawful-detention> (Accessed 19 April 2021).
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Appendix A – Data analysis and detailed methodology

We calculated descriptive statistics for the cases that lacked capacity, including the percentage of moves under each of the legal frameworks. For continuous variables such as age we calculated median and interquartile range (IQR)²¹ in order to compare across groups. We cross-tabulated the legality of the move with individual characteristics (age, gender, diagnosis, ethnicity and HSCP) to assess whether there are any differences based on these characteristics.

We created a stratified sampling process in which we sampled cases according to HSCP (based on population size, see Table B1) and age group (based on age distribution in all moves reported by PHS, see Table B2). From the list of cases we received, we ordered the cases randomly and reviewed each case for inclusion until we reached the target number for each HSCP. Our inclusion criteria for full review of the move were: i) the individual was discharged into a registered care home and lacked capacity to consent to the move, ii) the discharge occurred between 1 March 2020 and 31 May 2020, and iii) the person was aged 16 years or older.

In total we assessed 731 cases for inclusion. Of these, 465 (64%) people were assessed as lacking capacity to make an informed decision in relation to a move to a care home and 266 (36%) people reportedly had capacity to consent to the move. A number of people who had capacity also had diagnoses of mental health related conditions. Of those people who were reported as having capacity, we asked questions of the key contact to ensure that consent had been free and informed and recorded in case records. After excluding eight cases that ended up not fulfilling our inclusion criteria, we here report on 457 cases which we reviewed in detail.

Cases where the person was assessed as having capacity to decide on the move to a care home were noted in the list of received cases to track the proportion of moves that included individuals with and without capacity, only statistical information has been retained and all personal details about individuals assessed as having capacity has now been deleted from the Commission's server.

For cases where individuals lacked capacity, we used a proforma to collect the relevant information to determine which legal authority was used. Information on individuals who lacked capacity will be stored for three months after publication of this report and then deleted from the Commission's servers.

While we aimed to include 500 cases of individuals who lacked capacity, we had issues in some areas to fill the sample. In some HSCPs, the workload and remote working meant that there were limits to the engagement with the project that key contacts could provide within the time scale.

²¹ The IQR is a measure of spread of values, where the value for the third (75%) and first (25%) quartile are subtracted to indicate where there middle 50% of observed values.

Appendix B – Sampling

Table A1. Distribution of Scotland's population and corresponding numbers for target sample of N=500

HSCP	Population ^a	<64 years	65-84 years	85+ years	Total
Aberdeen City	4%	2	10	9	21
Aberdeenshire	5%	2	11	10	24
Angus	2%	1	5	5	11
Argyll and Bute	2%	1	4	3	8
Clackmannanshire and Stirling	3%	1	6	6	13
Dumfries and Galloway	3%	1	7	6	14
Dundee City	3%	1	7	6	14
East Ayrshire	2%	1	5	5	11
East Dunbartonshire	2%	1	5	4	10
East Lothian	2%	1	5	4	10
East Renfrewshire	2%	1	4	4	9
Edinburgh	10%	4	23	21	48
Falkirk	3%	1	7	6	15
Highland	4%	2	10	9	22
Inverclyde	1%	1	3	3	7
Midlothian	2%	1	4	3	8
Moray	2%	1	4	4	9
North Ayrshire	2%	1	6	5	12
Orkney Islands	0%	0	1	1	2
Renfrewshire	3%	1	8	7	16
Scottish Borders	2%	1	5	5	11
Shetland Islands	0%	0	1	1	2
South Ayrshire	2%	1	5	4	10
South Lanarkshire	6%	3	14	13	29
West Dunbartonshire	2%	1	4	3	8
West Lothian	3%	2	8	7	17
Western Isles	0%	0	1	1	2
Fife	7%	3	16	15	34
Perth and Kinross	3%	1	7	6	14
Glasgow City	12%	5	28	25	58
North Lanarkshire	6%	3	15	13	31

^a As percentage of the overall Scotland population. Highland was included in the estimated sample needed but did not provide information within the time frame (see Methodology).

Table A2. Distribution of moves according to gender and age

Age (years)	n (%)
<64	449 (9%)
65-84	2,511 (48%)
85+	2,244 (43%)
Total	5,204 (100%)

Source: Public Health Scotland

Appendix C – Sample summary

We looked into the circumstances of moves of 457 individuals who lacked capacity. Our sample included 59% female and 41% male individuals, which reflected the distribution of moves in the report published by PHS (also 59% female). The median age of individuals was 84 years (IQR=13), similar to overall moves in the same period reported by PHS (mean=81 years). Table C1 shows a breakdown of the demographic characteristics of individuals.

Table C1. Individual characteristics (N=457)

Characteristic	Category	n (%)
Gender	Male	188 (41)
	Female	269 (59)
Age, median (IQR)	—	84 (13)
Age group	<65 years	31 (7)
	65-84 years	207 (45)
	85+ years	219 (48)
Ethnicity	White Scottish	401 (88)
	White Other British	35 (8)
	Not provided	14 (3)
	Indian	*
	White Other	*
	Pakistani	*
	White Scottish and White Other British	*
	White Scottish and Indian	*
Diagnosis	Dementia	300 (66)
	Other	84 (18)
	Multiple diagnoses	38 (8)
	ABI	14 (3)
	MI	10 (2)
	ARBD	*
	LD	*

*number suppressed due to n<5 or due to secondary suppression

We found that 55% of the individuals were still in the care home they were admitted to following discharge from hospital.

Geographical area

We sampled cases from all HSCPs, apart from Highland (see Methodology section). Table C2 shows the number of cases and percentage of the total sample from each area. The largest percentage of cases were from Glasgow City (10%), Edinburgh (9%) and Fife (9%).

Table C2. HSCP of sampled cases

HSCP	n (%)
Aberdeen City	20 (4)
Aberdeenshire	20 (4)
Angus	10 (2)
Argyll and Bute	8 (2)
Borders	10 (2)
Dumfries and Galloway	14 (3)
Dundee	14 (3)
East Ayrshire	10 (2)
East Dunbartonshire	10 (2)
East Lothian	10 (2)
East Renfrewshire	8 (2)
Edinburgh	41 (9)
Falkirk	14 (3)
Fife	42 (9)
Glasgow City	44 (10)
Inverclyde	7 (2)
Midlothian	9 (2)
Moray	9 (2)
North Ayrshire	12 (3)
North Lanarkshire	33 (7)
Orkney	*
Perth and Kinross	15 (3)
Renfrewshire	15 (3)
Shetland	*
South Ayrshire	11 (2)
South Lanarkshire	27 (6)
Stirling and Clackmannashire	13 (3)
West Dunbartonshire	9 (2)
West Lothian	16 (4)
Western Isles	*
Total	457 (100)

*number suppressed due to n<5 or due to secondary suppression.

Note that Highland is not represented here. For more information see Methodology section.

Individual differences in legal authority used

We looked at the individual characteristics of individuals who were moved from hospital to care home. We looked at age, gender, diagnosis and whether or not the individual passed away following the move. We excluded the 'other' framework, as it only included nine individuals and the small number meant comparing across group would be inappropriate and provide little ability to make comparisons.

Due to very small number in many diagnostic categories, we compared Dementia (the largest group) with all other diagnoses or combination of diagnoses. There were too few individuals in other ethnicity categories than White Scottish or White Other British whereby no comparison was done between the three groups.

We found that 52% of individuals moved under WG/PoA were aged 85 years or older compared to 37% among s.13za moves and 40% no legal authority, however the median age did not differ much from s.13ZA (median age of no legal authority impacted by the small number). We also found a higher percentage of females among those moved on welfare guardianship or PoA and no legal authority (60% and 60%, respectively) compared to those moved under s.13ZA (52%).

There was a higher percentage of moves under welfare guardianship or no legal authority with diagnosis of dementia (74% and 75%, respectively) compared to s.13ZA (52%), which may to some extent be a factor of a higher median age among the former. Similarly, a higher percent of individuals moved under welfare guardianship or PoA had passed away – again likely influenced by a higher mean age in this group.

Table C3. Individual characteristics of the three main legal frameworks for moves

Characteristic	Category	Legal framework (N=448)			Total
		s.13ZA	WG/PoA	None	
Age, median (IQR)	—	81 (16)	83 (11)	85 (11)	84 (13)
Age group	<65	10 (10)	17 (6)	0	27 (6)
	65-84	46 (53)	144 (40)	12 (53)	202 (43)
	85+	34 (36)	177 (54)	8 (47)	219 (50)
Gender	Male	43 (48)	134 (40)	8 (40)	185 (41)
	Female	49 (52)	204 (60)	12 (60)	263 (59)
Diagnosis ^a	Dementia	47 (52)	250 (74)	14 (75)	212 (70)
	Other	43 (48)	5 (26)	88 (25)	136 (30)
Deceased	Yes	27 (30)	122 (36)	*	151 (34)
	No/not mentioned	66 (70)	216 (64)	*	297 (66)

^aAs most diagnostic categories had too few numbers in each for comparison, we have aggregated ABI, ARBD, MI, LD, other diagnoses and multiple diagnoses. Dementia includes individuals who had a main diagnosis of dementia with any other diagnosis in addition.



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